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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HL100017	A. BUILDING _____ B. WING _____	06/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALIFAX HEALTH MEDICAL CENTER	303 N CLYDE MORRIS BLVD DAYTONA BEACH, FL 32114

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H 000	INITIAL COMMENTS An unannounced complaint survey, CCR#2012005567, was conducted at Halifax Medical Center, 303 N. Clyde Morris Boulevard, Daytona Beach, Florida, on June 11-12, 2012. Halifax Medical Center is NOT in compliance with FAC 59A-3, State Licensure Requirements for Hospitals.	H 000	RECEIVED JUL - 6 2012 AHCA - HQA-4	
H 199	59A-3 FAC SURVEILL PREVEN & CONTROL OF INFECTION (1) Each hospital shall establish an infection control program involving members of the organized medical staff, the nursing staff, other professional staff as appropriate, and administration. The program shall provide for: (a) The surveillance, prevention, and control of infections among patients and personnel; (b) The establishment of a system for identifying, reporting, evaluating and maintaining records of infections; (c) Ongoing review and evaluation of all septic, isolation and sanitation techniques employed in the hospital; and (d) Development and coordination of training programs in infection control for all hospital personnel. This Statute or Rule is not met as evidenced by: Based on observation, interviews with staff, and review of documents Halifax Medical Center is not in compliance with the Condition of Infection	H 199	Action Item #23 Review and revision of the "Infection Control Program" policy	6/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Terri Long RN, BSN. LHCRM — TITLE: Clinical Risk Mgr — (X6) DATE: 7/5/12

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H 199	Continued From page 1 Control, 482.42, which requires the hospital to provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. In addition, there must be an active program for the prevention, control, and investigation of infections and communicable diseases. The failure to provide an effective program is evidenced by; The facility infection control officer failed to develop or implement policies which are based on current national standards, educate staff, and monitor cleaning and disinfecting for terminal cleaning of rooms (Standard 482.42(a). The findings include: Interview was conducted with the nurse manager for the Intensive Medical Care (IMC) unit on 6/11/12, at 11:00am regarding the recent outbreak of Acinetobacter Baumannii and measures in the unit. The Nurse Manager stated that two new products were in use for environmental cleaning and disinfection of rooms; HDQ Neutral one-step disinfection and the Bioquell vaporized hydrogen peroxide machine. When asked regarding terminal cleaning of the rooms; she stated that the room is stripped of all linen and cubical curtains and then the terminal cleaning is performed. Interview of the Environmental Services Manager on 6/11/12, regarding terminal cleaning of rooms was conducted. He stated that cubical curtains are removed prior to terminal cleaning for Clostridium Difficile (C-Diff) bacteria, Methicillin Resistant Staphyloccoccus Aureus (MRSA) bacteria, and Acinetobacter bacteria and also when there was visable soil on them. Review of Infection Control Environmental policies and procedures for terminal cleaning; Effective 2/26/1991, Revised 7/21/2011, page 3; Draperies and Cubical Curtains, a). Housekeeping will remove draperies for cleaning	H 199	Action Item 24 Review and revision of "Cleaning" and "Terminal Cleaning" policy. Action Item #25 Educate staff on policy revisions. Action Item #26 Audits by Environmental Supervisors to assure compliance with policy changes for a 3 month period with >/= 95% compliance.	7/12/12 7/12/12 Begin 7/12/12 Ending 10/12/12

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H 199	Continued From page 2 and re-hang them once a year or as often as needed. Page 7; Drapes should be vacuumed and laundered when soiled. Page 11; 5). Isolation Rooms, Terminal Cleaning; Remove the drapes and place in linen bag. On 6/12/12; a discussion was conducted with the Chief Nursing Officer, Quality Manager, Contract Infection Control Practitioner and Risk Manager regarding the Infection Control policies. The facility Infection Control Policy for Environmental Cleaning and Disinfection is not current or based on a national standard. Observation of staff on 4 North, telemetry unit on 6/11/2012 at10:30 AM, revealed one nurse caring for a patient on contact and droplet precautions who did not have her gown properly fastened at the neck, causing her to frequently pull the gown over her shoulders to try to keep her uniform covered. Observation of a housekeeper on 6/11/12 at 12:10 PM on 4 North revealed that she did not have a gown on when she was cleaning an isolation room. When the housekeeper was approached by the Joint Commission Coordinator, the housekeeper did not understand what the Joint Commission Coordinator was saying. The facility also failed to assure that the infection control officer or officers develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel (Standard 482.42(a)(1). An interview with the Director of Quality and Outcomes on 6/11/12 at 1:25pm revealed that two previous employees in Infection Control both left their positions on January 25. She stated that the hospital had contracted with an Infection Preventionist, a Registered Nurse (RN), for the interim but she did not fulfill her contract and did not send appropriate reports to the Department of	H 199	Action Item #27 Review and revision of the "Surveillance Program"" policy.	6/12

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H 199	Continued From page 3 Health. Her contract was not made available to the surveyors. Two weeks ago the hospital contracted with another Infection Preventionist, a RN, and hired a second Infection Preventionist, a Microbiologist, to lead the Infection Control department. The hospital has also hired a Medical Technologist who is certified in Infection Control, in an interim position to do lab based surveillance and validate culture reports from January through May. In addition the hospital is hiring a clerical person to support them. An interview with the Director of Quality and Outcomes on 6/12/2012 8:30 AM, revealed that from January 25 to February 21 there was no Infection Preventionist on staff. An interview with the Chief Medical Officer on 6/12/2012 at 10:00 AM, revealed that he was the interim Infection Control physician since the former Infection Control physician, had left the organization in February. He stated that Infectious Diseases was not his specialty but he was willing to fill in until an appropriate physician is brought on the medical staff. The Chief Medical Officer stated that he and the former Infection Control physician had discussed the issue of Acinetobacter Baumanii a number of times and he indicated that administration was concerned. He indicated that the issue had not been discussed at medical staff department meetings as they were struggling with how to address the issue. He indicated that the hospital has made changes due to a lack of effective leadership with this problem since 2010. An interview with the Chief Nursing Officer (CNO) on 6/12/2012 at 10:35 AM revealed that the medical staff had received correspondence from the Chief Medical Officer in 2010 restricting the use of Carbapenem. She indicated that the issue with Acinetobacter has not been reported to	H 199	Action Item 28 Time-line of coverage of Infection Prevention and Control with Supportive documentation.	6/28/12

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H 199	Continued From page 4 Quality Council and that the Infection Control minutes are not a topic in Governing body or Medical Staff. She indicated that the first cases of Acinetobacter in 2010 were discussed with hospital leadership. This year, 2012, the Department of Health (DOH) returned to review actions taken and found that their recommendations had not been implemented. Review of the Medical Executive Committee minutes of 3/13/2011 and 12/13/2011 revealed that the Infection Control physician reported on the incidence of Acinetobacter and the committee conclusion was that Infection Control will continue to monitor and report its surveillance. An interview with the Chief Executive Officer (CEO) on 6/12/12 at 2:00 PM revealed that the issue with Acinetobacter was not reported to the Board. He stated that they were not sure where it was coming from; whether it was internal or external. He stated that they had a lot of internal discussion but it was not discussed at meetings. Review of the Infection Control minutes (2/24/2011; 3/30/2011; 10/26/2011; 11/30/2011; and 1/10/2012) revealed that cases of Acinetobacter were reported in the meetings but the only conclusions were that the committee would continue to monitor and report surveillance of Multi Drug Resistant Organisms (MDRO). Two action plans that were located were given to the surveyors following the exit conference. The first plan was from 2010 and the second plan was not dated. However, six of the eight action items on the second plan were noted as completed but no dates were included. Widespread Correction date 7/12/12	H 199	Action Item #29 Committee reporting structure reviewed. Action Item #30 Update current action plan with completion dates and supportive data.	7/3/12 7/2/12

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H 208	Continued From page 5	H 208		
H 208	59A-3 FAC GOVERNING BODY (1) The licensee shall have a governing body responsible for the conduct of the hospital as a functioning institution This Statute or Rule is not met as evidenced by: Based on facility provided documentation including General Medical Staff Minutes, interviews including the Chief Medical Officer, Director of Quality, Risk Manager and the Chief Executive Officer on 6/12/12 at varying times the facility failed to ensure the governing body was responsible for the conduct of the hospital, and of the monitoring of care given to those patients who are infected with the Acinetobacter Baumanannii organism. Based on this information Halifax Medical Center is not in compliance with the Condition of Participation for Medical Staff (482.22). The findings include: Facility provided documentation revealed an Acinetobacter Baumannii outbreak at Halifax Medical Center in July 2010 through May 2012. Interview with the Director of Quality who oversees the Infection Control program on 6/12/12 at 10:00a.m revealed there were 21 cases of Acinetobacter Baumannii in 2011; with no evidence presented to identify this was an actual number . There have been 17 new cases of Acinetobacter Baumannii from January 2012 through May 2012; with eight new cases being diagnosed in January 2012. Of the eight new cases, four were of colonized patients. The Director of Quality stated had a Director of Infectious Disease whose contract was not renewed left the facility sometime between 1/26/12 and the beginning of February 2012 (date uncertain). Evidence of the contract was not presented upon request. The two staff	H 208	Action Item #31 Line listing to include:MR #, admit date, discharge date, arrived from, admitting diagnosis, hosp. acq/comm. acq/colonized, VCHD notification, terminal clean.	7/12/12

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H 208	Continued From page 6 members, a registered nurse and a medical technologist who were the infection control team resigned their positions on 1/26/12. The facility was without any type of infection control oversight from 1/26/12 thru 2/21/12 when a contracted off-site person was employed. It was determined at some date that this contracted person was not performing her contracted duties. A second outside company was contracted and two new contracted persons and one new hospital employee were hired approximately 2 weeks prior to this investigation. Interview with the former medical technologist of the infection control team who is still employed as a laboratory person on 6/12/12 at 1230pm revealed that the microbiology section of the laboratory staff send reports directly to the Health department due to there " being no infection control department " . Interview with the Risk Manager on 6/11/12 during the day at various times revealed the former Director of Infectious Department did not allow surveillance cultures to be taken on new admissions. The former Director of Infectious Disease disagreed with the Health Department stating Halifax Medical Center did not have an outbreak of Acinetobacter Baumannii. The Risk Manager stated the former Director of infectious Diseases reviewed all medical records of patients who had expired and had an Acinetobacter Baumannii infection, and he had determined the organism was unrelated to their deaths. (There was no evidence presented of this review when requested). The Risk Manager stated that the former Director of Infection Control did edit all minutes from the Infection Control committee and the Quality Improvement Committee. There was no evidence presented that any information from the Infection Control Committee was reported to the governing body.	H 208	Action Item #32 Documentation of the old process of reporting to the Health Department, and recent changes to that process. Action Item #33 Requested documentation from Dr. Duma verifying his review of cases.	7/12/12 7/2/12

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H 208	Continued From page 7 Interview with the Chief Medical Officer on 6/12/12 at 2pm revealed the previous Director of Infectious Disease had reviewed all cases of patients with Acinetobacter Baumannii, but that there was no written documentation to support this. He stated he spoke to several physicians about the Acinetobacter Baumannii infestation, but had no evidence of these conversations. He stated the Acinetobacter Baumannii was not addressed at a department level, stating, " We were struggling with how to address it". Interview with the Chief Nursing Officer on 6/12/12 at 2pm revealed the Infection Control Committee minutes do not go to the Governing Board or the Medical Staff. Interview with the Chief Executive Officer on 6/12/12 at 2:00p.m revealed there was no formal notification to the governing board members on the Acinetobacter Baumannii infection infestation, stating " we don ' t know where its coming from; or who has it- what would we report? " Review of the Halifax Health Organization Chart revised on 5/17/12 revealed all personnel and departments report to the Chief Executive Officer, who reports to the patient and not the Governing Board. The medical staff nor the governing board is not identified any place on the chart. Medical record review of two decreased patients (#17 and #18) which was listed by the facility of having a positive culture for Acinetobacter Baumannii, revealed the facility ' s medical staff failed to list the multi-drug resistant organism as a primary or secondary diagnosis on the discharge summaries. Patient #17 discharge summary revealed findings addressing infectious diseases and sepsis including; pseudomonas, clostridium difficile, and staphylococcus epidermis. The patient ' s positive cultures for Acinetobacter Baumannii in the sputum and wound were not	H 208	Action Item #34 Requested documentation from Dr. Duma that reflects he had conversations with various members the medical staff related to Acinetobacter baumannii. Letter from Dr. V. Wilson, Chair of Medicine verifying the discussion. Action Item #35 Review and revise organizational chart.	7/2/12 7/2/12 7/12/12

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H 208	Continued From page 8 included as significant. The discharge summary for Patient #18 listed thirty-five diagnosis which included staph aureus klebsiella pnemononiae ; the positive urine culture for Acinetobacter Baumannii was not listed or documented as being a significant finding. Patient #17 and #18 medical records were reviewed with the Director of Quality on 6/12/12 at 2:15pm, which revealed the previous Infection Control Physician had reviewed all cases of Acinetobacter Baumannii, with no documentation being presented of this review when requested. Review of the General Medical Staff Committee minutes (which only meets biannually) dated 3/13/12 revealed no concerns or mention of the Acinetobacter Baumannii organism, or patients infected, or a preventive plan. There was no evidence t presented during the survey on 6/11/12 and 6/12/12 or additional information provided to AHCA on 6/15/12 that Halifax Medical Center governing board was aware of the Acinetobacter Baumannii infestation, nor of the severity of the infection, including number of patients involved, nor of any or if a preventive plan was in place. Widespread Correction date 7/12/12	H 208	Action Item 36 Communication about the inclusion of all diagnosis' related to patients admission sent to the Chair of each department. Action Item #37 STAT newsletter to include a reminder to the Medical Staff about including all diagnosis' in the discharge summary. Action Item #38 Communication placed on the physician portal on PULSE related to discharge summaries. Action Item #39 Communication placed on the monitor in the physicians lounge related to complete discharge summaries. Action Item #40 Audits will be conducted for a 3 month period by the Infection Preventionist on the medical records of patients with Acinetobacter baumannii for inclusion in the discharge summary with a rate of compliance to be >/= 95%.	7/3/12 7/3/12 7/3/12 7/3/12 Begin 7/12/12 Ending 10/12/12

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

June 27, 2012

Terri Long, R.N., Risk Manager
Halifax Health Medical Center
303 North Clyde Morris Boulevard
Daytona Beach, FL 32114

Facsimile Transmittal:
386/238-5735

Dear Ms. Long:

Re: CCR #2012005567

This letter reports the findings of a complaint survey of your facility conducted on June 11-12, 2012, by representative(s) of this office. It was determined the **Halifax Health Medical Center** was not in compliance.

The following Conditions of Participation) were Not Met:

Fed - A - 0338 - 482.22 - Medical Staff
Fed - A - 0747 - 482.42 - Infection Control

Attached is your copy of the *Statement of Deficiencies and Plan of Correction*, Form CMS 2567, which references all of the Federal deficiencies. Also attached is your copy of the *State (3020) Form,* which references all of the State licensure deficiencies.

You must provide this Agency with an acceptable Plan of Correction (PoC) for all deficiencies cited **within ten calendar days** from receipt of the *Statement of Deficiencies and Plan of Correction*, Form CMS 2567 and *State (3020) Form*. Please complete a Plan of Correction (PoC) for the deficiencies, including the date corrective action was accomplished or is anticipated to be accomplished. Please sign and date page 1 on the bottom and return to this Field Office within ten calendar days of receipt of this faxed report. Failure to submit a reply within this time frame may jeopardize your certification status. **All deficiencies must be corrected no later than July 12, 2012.**

In order for a PoC to be acceptable, it must include the following elements:

Core Elements of PoC:

- How the corrective action will be accomplished for individuals found to have

Headquarters
2727 Mahan Drive
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Jacksonville Field Office
921 N. Davis St., Bldg. A, Suite 115
Jacksonville, FL 32209
Phone (904) 798-4201; Fax (904) 359-6054

been affected by the deficient practice;
- How the facility will identify other individuals who have the potential to be affected by the same deficient practice, and how the facility will act to protect individuals in similar situations;
- What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent; and
- When corrective action must be accomplished.

Be advised that the Agency is recommending termination of your Medicare/Medicaid participation to be effective September 12, 2012 which is 90 days from the date of the survey. The termination process provides an opportunity for you to make corrections and achieve compliance. A revisit will be conducted within 45 days of the survey if a PoC is received and accepted. The revisit will determine if your facility is in compliance with the Conditions of Participation.

The *Quality Assurance Questionnaire* has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). If you have questions, please contact us at (904) 798-4201.

Sincerely,

Robert E. Dickson
Field Office Manager
Division of Health Quality Assurance

RED/JH/CD/AS/je
Enclosure

EESW